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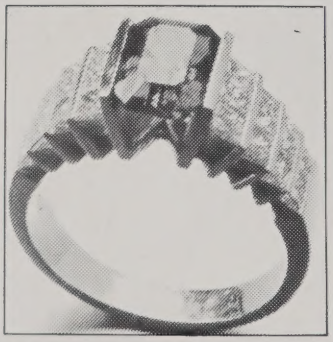

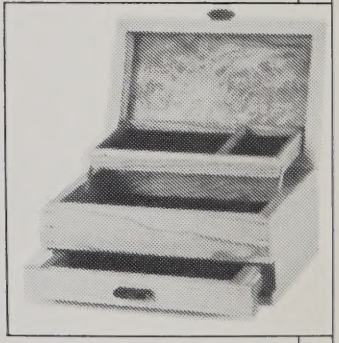

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THE HAMPDEN HIPPOCRAT

VOLUME XXXXIV NO. 4
August—September 1988

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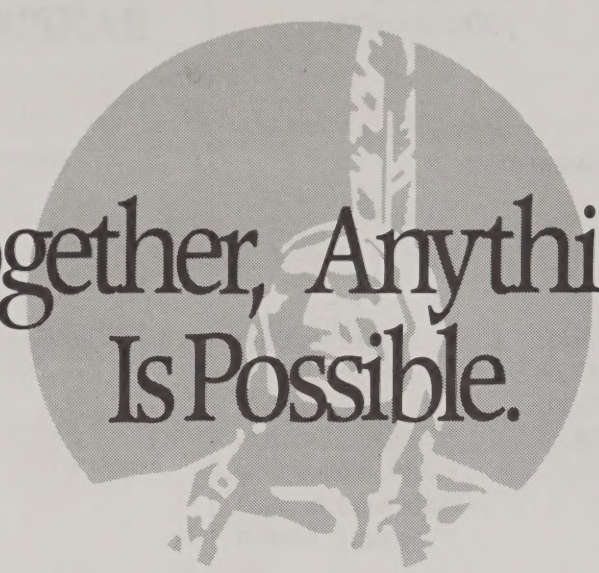

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THE HAMPDEN HIPPOCRAT

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August—September 1988

VOLUME XXXXIV NO. 4

The official bulletin for The Hampden District of the Massachusetts Medical Society. Founded in 1942 by Edward P. Bagg, Jr., M.D. and William A. R. Chapin, M.D.

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This month's cover is "A Child's Tears Erased" the First Prize Winner of Pride in Medicine II. Submitted by Maria Iacobo of Children's Hospital in Boston Massachusetts.

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HDMS President's Message

Division Versus Cohesion

J. Gordon Rich, M.D., President

Some years ago, Terry Ryan wrote in this column about some of the forces that are tending to split our ranks and fragment our efforts. Since then these centrifugal influences have multiplied and become more of a problem. "Organized medicine" has often been perceived as representing physicians in private practice, and I think the reasons for this are rooted in the history of our profession in this particular country.

All medical practice—both "regular" and "unorthodox" was originally "private". There was really no other mode of health care delivery from colonial times until relatively recently. When medical societies and other professional associations tried to address issues and problems, they did so on behalf of "private practitioners" because there were no other kinds of health care providers. There were no teaching staffs, or hospital based "full-timers", closed panel HMO's, or physician-administrators. Physician employees were virtually non-existent. Inevitabley, the link between medical organizations (national, state, and local) and people in private practice has been and remains a strong one.

Locally, much of our district society membership, and those who have been most involved in its activities, and most devoted to it, have tended to be private practitioners. There have been some notable exceptions: Our Treasurer, Dr. Remsberg, comes to mind as an example of a non-private physician who has worked long and hard on behalf of our district society. In the main, however, private practitioners have been most involved, and have done most of the work of the society over the years. This has been the group that we have relied on most particularly, and their influence over our affairs has been correspondingly prominent. It has been difficult to engender enthusiasm and support from employed physicians in any large numbers. This is a situation which your Officers and Executive Committee would like to see change drastically.

More often than not "organized medicine" speaks for the profession as a whole, and it is necessary for *all* segments of the profession to formulate its opinions and chart its future activities. I would like to see physicians of all persuasions participate in large numbers in our affairs, and have a voice in this organization. Indeed, this broadening of participation and support is important now, and will become more so in the future.

Often, I have heard physicians who are not in private

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practice state that they felt that organized medicine and its activities were not germane to their professional lives. I think that this is a misguided point of view. The benchmark of how physicians are treated in our society: their status, remuneration, working conditions, etc., has generally been crouched in terms of what is currently going on in private practice. If a hospital or other entity wishes to hire and retain a physician, that institution must come up with a proposal commensurate to and competitive with what that individual could achieve in the private sector. Indeed, we have seen a number of instances in which employed physicians have left their employer's service to strike out on their own or in private groups. The presence of a strong private practice component on the local scene has provided a de facto set of checks and balances which have benefited employed physicians in their dealing with hospitals, HMO's, and other entities.

If the situation of private practitioners erodes substantially, be assured that physicians in other modes of activity will see their situations erode as well. In a very real sense, we are all in this together.

Another area of concern is the tendency of the profession to fragment into specialty and sub-specialty groupings. I have heard it said often that the district and state organizations do not address issues of particular concern to specialty practitioners, or even the particular concerns of "generalists". This has led to a proliferation of statewide subspecialty organizations—each with its own agenda and issues to pursue. I think that subspecialty societies are important and useful, but when it comes to dealing with the "big picture", and issues that affect us all; we all need to be under the same tent. We can have an impact on problems such as professional liability, mandatory Medicaid participation, mandatory acceptance of Medicare assignment, etc., only if we are all in the same war canoe and paddling like hell in the same direction.

There are perhaps between eleven and thirteen thousand physicians who are providing full time patient care in this state (nobody knows for sure what the precise number is). We are trying to influence what goes on in a body politic of about five and a half million souls. Unless we are united, and working together, we have no chance at all of having a desired impact on present and future events.

Finally, I would like to talk about a subject that could well rip our fabric of cohesiveness to shreds. This summer the folks at the Harvard School of Public Health will be reporting to Congress the results of their research and ponderings on a Resource Based Relative Value Scale. This is already pitting the "procedurists" against the "cognators". If we get seriously split up over this explosive issue, there may be some short term winners, but I submit that we will surely all be long term losers.

Let's see if we can't get together, stick together, and work together for the benefit of all those invloved in our health care system—patients first, but providers also.

To those of you who aren't of H.D.M.S., or who aren't involved in its work—Come on in; the waters fine. ■

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Sick Health Services *Editorial Comments*

The cost and delivery of reasonable health care appears to be straining the resources of the countries throughout Western Civilization. On the date that this was prepared for publication in the Hippocrat, Sunday, August 7, 1988 there is a headlined article in the Springfield Republican entitled "San Francisco Hospital Strike Grows As More Nurses, Workers Walk Out". The front page of the New York Times has two health related articles. One headlined "U.S. Studies Ways to Speed Drugs For Seriously Ill" and the second entitled "British Health Service Faces a Crisis in Funds and Delays." This particular article by Steve Lohr begins,

> "New Castle, England, August 3, 1988, Barry Bowdeswell, General Manager of the Royal Victoria Infirmary, here stands at the front line of Britain's troubled National Health Service, once used as a world model of a successful national medical service.
>
> Touring the big New Castle Hospital, he explains that his staff of 3,500 is often fighting a losing battle against increased demand, essentially rationing health care for lack of funds."

The follwing article entitled "Sick Health Services" appeared in the previous week's issue of 16-22-July, 1988, of "The Economist" of London. It is reprinted here with the suggestion that there is a common thread which connects the health problems of the Western Civilization on both sides of the Atlantic and that over the next decade the governments and health planners are apt to study the best and the worst of each type of health care.

As this article suggests, if the economies of the countries of western Europe are to become more unified in the 1990's under the EEC, the many differences in their health care systems will probably have to fall in line also. As the world shrinks and as our approach to problems become more universal it is probably only a matter of time before a common approach to medical care spreads across the Atlantic. The major impediment to this, ironically, is probably the differences in medical liability that seperate our system of medical care from those of all others in the world. Will our hospitals become the cathedrals of the future, visited for historic interest only? The following article perhaps raises more questions than it answers, but it may broaden the reader's view of medical care. We can all afford to become less parochial.

The Editor

SICK HEALTH SERVICES, Reprinted from the Economist 16-22-July, 1988

Sick Health Services
Europeons seek the right treatment

In trying to improve their health services, European countries face strikingly similar problems. They could learn from each other.

One of the most urgent tasks for rich countries over the next decade is to make their health-care systems less costly and more effective. It will not be easy—vested interests are threatened. The first signs of political trouble are already appearing. Ireland's government nearly fell when it tried to close a hospital last year. In Holland the coalition government almost came adrift over proposals to change the state health-insurance system and narrow its coverage.

A look at health care in the 24 mainly rich member countries of the Organisation for Economic Co-operation and Development (OECD) reveals curious paradoxes. Medical practice is similar everywhere and doctors quickly learn of medical advances made in other countries. Yet there are bigger differences between OECD members in the organisation and financing of health care than in almost any other activity.

A second paradox is that there is little connection between the amount a country spends and the health of its people. In the EEC the shortest life expectancy for men is found in Ireland, the longest in Greece. Yet Ireland devotes the biggest share of its GDP to health care, Greece the smallest. Improvements in health usually stem from factors right outside the narrow field of health care—changes in diet, for instance.

The biggest paradox is that though rich countries have such different health systems their problems are the same: how to subject doctors and hospitals to financial disciplines, how to secure adequate treatment for the poor and the old, how to find enough nurses from shrinking teenage populations—and how to control an apparently infinite demand for health care. Yet parochialism remains entrenched. The Dutch "Dekker" commission has few contacts with West Germany's "concerted-action" group of advisers. Links between private organizations like the British King's Fund and French Institut la Boetie are also underdeveloped. This article looks for common threads, starting with health care in Sweden, West Germany and France.

Sweden, like other Nordic countries, has a highly developed welfare state. As befits a rich country with

continued

the world's highest proportion of old people in its population it spends a lot on health care—over 9% of GDP, though (see chart on next page) the percentage had recently been falling. Nearly all the money comes from taxes or compulsory state insurance, though patient charges are high in comparison with other countries: $8.50 for each visit to the doctor or non-life-saving drug prescription, with no exemptions but with an annual limit per patient of around $130.

The Swedish system is largely run by local county councils, which jealously guard their autonomy against central incursion. Despite its generous financing, Swedish health care has its problems. Patients wait up to two years for some operations, including heart surgery and cataract removals. Neither doctors nor county hospitals have an interest in eliminating inefficiencies. Too many general practitioners work in the southern part of the country. Patients are sent too readily to specialist doctors or into hospitals.

Swedes remain attached to the financing of health care from taxation. But they are trying to promote competition by among other things, blurring the demarcation line between public and private medicine. At the Sophiahemmet in Stockholm, Sweden's biggest private hospital, a quarter of the patients are now paid for by county councils at a fixed-price per case. The use of competitive tendering for support services is growing, despite union opposition.

The health ministry wants county councils to compete against each other. It offered the counties some $10m last year to reduce the longest waiting times—but with the bonus of extra subsidies to counties which, by shortening queues, attracted patients from their neighbors. If they spread, such incentives to make hospitals and doctors more cost-conscious could clear the way for such overdue changes as bigger regional pay variations, more flexible local management and wider use of generic drugs.

West Germany spends less of its GDP on health than Sweden and has barely any waiting lists. In other respects its system is worse, which is why the federal government is pushing through a new health-care law this summer.

The Germans proudly present Bismarck as the inventor in 1883 of compulsory social insurance and so the great-grandfather of a better sort of welfare state than the Anglo-Swedish version. But average contributions to one of the hundreds of state-sickness funds have risen to 13% of pay, split equally between employers and employees. The ability of the better-off to opt out and take private insurance means that richer people, who are usually healthier, desert the state system. They often get better care than those left behind—though some try to return when their incomes fall or their need for treatment rises. Until recently West Germany had no mechanism for restraining costs—an expensive mistake in a country that has too many doctors, too much medical equipment and too many hospital beds.

A new law that aims to reduce health spending by about 15% is currently causing consternation among

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Sick Health Services

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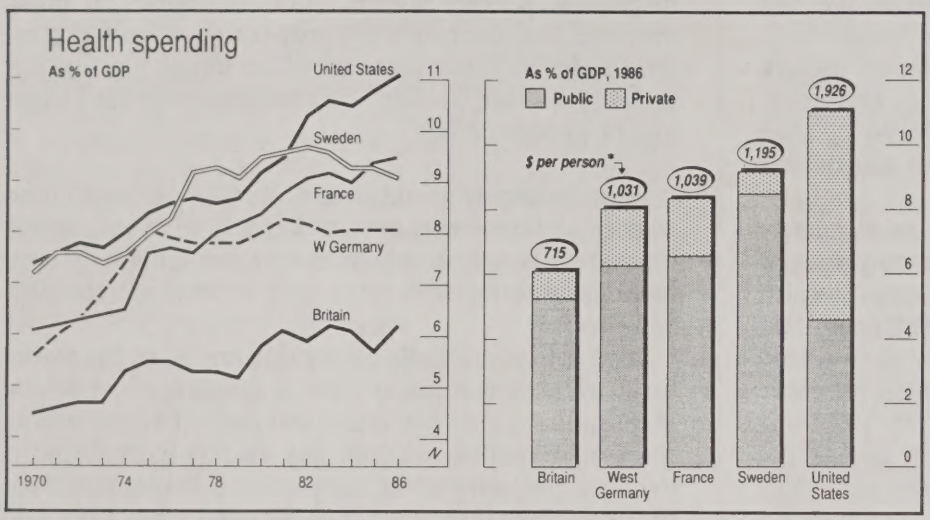

Source: OECD

* Converted at purchasing-power parity

the West German states that run most of the public hospitals. The federal government has already stopped some of the wildest extravagances by banning state-insurance financing of rest-cures, drawing up a limited list of drugs eligible for reimbursement and introducing some cash limits for hospitals. Now it plans to encourage the substitution of cheap generic drugs for expensive brand-name ones, to raise prescription charges and to let state-sickness funds cancel contracts with hospitals. Since both public and private hospitals depend largely on the sickness funds for their income, this should make it easier to close surplus capacity—provided hospitals are not allowed to lengthen already-long patient stays.

West Germany's biggest problems are outside the hospitals. Most doctors work in clinics on a piecework basis that has encouraged American-style extravagance: lots of unnecessary tests that are often repeated when a patient goes into the hospital, too many x-ray machines, enough lithotripters to smash every kidney-stone in Europe. Thanks partly to the influence of the big German drug companies, pharmaceutical prices are the highest in Europe. The drugs bill absorbs 15% of health-care spending—twice as much as in most other countries.

France, like West Germany, finances health care through a Bismarckian compulsory social-insurance system. But its detailed operation is completely different. About 70% of medical costs are paid by the state social-security fund (the SECU). Most French people get help with the rest through supplementary payments to one of the private-insurance groups known as mutuelles.

The French version of social insurance has two striking features. The first is high direct payments by patients. Although they cover most hospital expenses, neither the SECU nor the *mutuelles* reimburse in full the expenses of visits to the doctor or medicines. The so-called *ticket moderateur* means that user charges meet up to a quarter of the cost.

Most French people now have to pay nearly $15.00 to see a general practitioner. And the burden of direct payments is increasing. The "plan Seguin" (named after Mr. Jacques Chirac's health minister) stopped full refunds for drugs for the old and chronically sick, though the new French government may change this. The gap between average consultation fees and what the SECU of the *mutuelles* will pay is widening.

The second Gallic peculiarity is that the system is awash with paper. Every treatment involves forms; and claims for reimbursement have to go to several organizations. By one count, about 250,000 people administer French health care, at a cost equivalent to 8% of total health spending.

Despite the deterrent effect of high charges and lots of paperwork, France spends a bigger (and faster rising) share of its GDP on health than West Germany. Contributions to the SECU—which anyway often have to be topped up by central government—amount to 18% of salaries, split two-thirds to one-third between employer and employee. The French government has forced pharmaceutical prices down to the lowest level in Europe; but the bill is still huge because of the French penchant for pills (the average Frenchman gets 28 prescriptions a year, the average Briton only seven). France's hospitals too are expensive by British standards.

One reason for this relative extravagance is the absence of incentives to economise. Doctors outside hospitals compete fiercely for custom—and they often dish out unnecessary prescriptions to disuade patients from going to a rival who would oblige them. Public and private hospitals know that their patients' bills will be paid, so they go in for lavish facilities and put quality of care ahead of cost-control. That is now changing as the French (ahead of other European countries) adopt "diagnosis-ralated groups"—cash-limited payments for courses of treatment in hospitals calculated as averages that do not vary with lengths of stay. DRGs give hospitals a strong incentive to control their costs.

The Search For A Better Way

Most European health systems are similar to one of these three models. **Britain's** National Health Service differs from Sweden's largely in being centrally (not locally) financed and run. **Ireland, Denmark** and **Norway** also pay for most health care from taxation and

and deliver it through publicly owned institutions. **Italy** replaced its social-insurance system with a National Health Service in 1980. The **Benelux** countries operate variants of the Franco-German social-insurance system. Across the Atlantic, **America** is unusual in paying for over half its health care privately. **Canada** switched over to public financing in the early 1970's—which has helped it contain health-care spending to 8½% of GDP while America's has risen to 11%.

The search for improvements that all countries are making throws up some common themes, lessons and difficulties.

• There is a serious lack of information on the costs, benefits and output of all health services. Management, financial control and accountability suffer. The use of cash-limited budgets in place of fee-for-service is producing more cost-consciousness. The spread of computers is also helping. But the introduction of financial considerations into medical practice is often resisted by doctors anxious to preserve "clinical freedom."

• Perverse incentives are rife. In many systems, doctors earn more money if they do more tests or provide more treatment. Hospitals, unless subjected to tight cash limits, often have a financial interest in keeping patients in hospital as long as possible. Doctors who want to make a case for more resources (or, less commendably, to boost their private practices) find it pays to appear overloaded even if that means inefficiency.

• Patients are having to pay more almost everywhere. Prescription charges for medicines are common. Many countries have exemptions for old or chronically sick patients; some countries charge for routine (but not for life-saving) drugs. Charges for consulting doctors are less widespread and charges for stays in hospital remain rare. Academic studies suggest that modest charges provide people with a useful reminder that health care costs money. This reduces a tendency to over-use medical services without, apparently, deterring people from seeking the treatment they really need.

• Although the truism "prevention is better than cure" is widely preached, it is seldom practiced. Most "health" services are really "sickness" services that offer lots of treatment and medicine but not much advice on how to stay healthy. Europe's great public-health movement that led to better sanitation, diet, housing and the spread of inoculation over the past century has faded away. In future, genetic advances and improved screening techniques will make a revival of preventive care doubly desirable.

• Primary care is generally under-developed. The strongest family-doctor network is in Britain, where it deals with 90% of all episodes of illness. In most other countries family doctors are thin on the ground, medical records are poorly-kept and too many patients are referred straight to expensive specialist doctors or hospitals.

• Lobbying by the pharmaceutical industry has dissuaded governments from pressing for the use of cheaper (but therapeutically equivalent) generics in place of branded drugs. This is changing: "limited" lists are more common than they were. Drug prices are usually higher in countries with a powerful drug industry. The EEC's move to a frontier-free Europe will make it harder to sustain such price differences: already "parallel" imports are undermining them.

• Big variations in efficiency, cost and quality of care are found everywhere. In Britain the health department's

continued

Health Compared

	Sweden	West Germany	France	Britain	United States
Doctors per 10,000 population	26	26	24	14	23
Acute hospital beds per 10,000 population	138	109	107	77	58
Average length of hospital stay, days	22	17	9	11	7
Infant mortality rate per 1,000 live births	5.9	8.6	7.7	9.5	10.4
Life expectancy for men, years	74.0	71.2	72.0	71.5	71.3

Source: OECD, Latest available date.

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Sick Health Services

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performance indicators have shown huge differences between health authorities. In France there are marked differences between hospital costs. Such variations suggest that savings could be made and services improved if those responsible for health care were readier to learn from one another.

Three principles should guide policy-makers seeking to improve health care. First, incentives for doctors, managers, hospital owners and patients need to aim in the right directions. Second, competition between providers is often a good way of achieving this: not merely tendering for hospital cleaners and cooks, but competition between doctors and hospitals to attract patients or win contracts with health-care financing organizations. Sometimes a separation of financing from delivery will help secure the benefits of competition.

Third, however, competition cannot be unrestrained; it needs to be "managed". Otherwise it can lead to waste, duplication and resource misallocation—because of the insulation of patients from costs and because the amount and kind of health treatment they get depends largely on the advice and decisions of professional providers.

Embarras De Richesse

In applying these principles, all European countries need to bear in mind that they have **too many hosptial beds**. As medicine has become more efficient, average lengths of stay in acute hospitals in OECD countries have tumbled, by a third in the past 25 years. Yet bed provision and lengths of stay still vary strikingly between countries (see table on previous page). And American experience suggests that nearly half of all surgery could now be done within a day. Health economists in France and West Germany reckon their hospital overcapacity is 30% and growing. Mr. Jean-Pierre Poullier of the OECD predicts wryly that hospitals could become the cathedrals of the future, visited for historical interest only—and maintained at vast expense.

For hospitals are not being shut to match falling lengths of stay. They are often the biggest local employers, and their workforces can be relied on to oppose closure. Local communities are very attached to local hospitals, and it is hard to explain to those waiting for treatment that queues are more often a sign of inefficiency than of bed shortages. There are, for instance, too many hospital beds in London. Yet hospitals are often overflowing, thanks to high lengths of stay and the cluttering up of wards with old people who might be better looked after outside hospital altogether. This makes the politics of hospital closures even trickier.

One solution that governments could try is being pioneered in Belguim: give hospitals and their staff financial inducements to switch from acute-surgical care to the care of the chronically or mentally sick. Such a switch would match changing need as the practice of medicine moves away from curing towards caring. Tomorrow's armies of old people will need health services that concentrate more on looking after them than cutting them open for surgery.

Partly because of this changing pattern of need, most countries (though not Britain) also have or soon will have **too many doctors**. A surplus of doctors can help to undermine the profession's restrictive practices and encourage competition, as has happened in America in the past 20 years. But in the short run it can also cause costs to soar. The average practicing doctor generates over $1m of spending on health care a year. Doctors still have a lot of scope, especially outside hospitals, to drum up demand for their services. Doctor-training is expensive. So most European countries (but not Italy or Belgium) have imposed limits on the number of students admitted to medical schools. But the limits still look high in relation to likely future need.

As travel to or work in other European Countries becomes more common, there may also be more **cross-border health-care**. Patients waiting for three years for a hip replacement in Britain may, for instance, go to West Germany where thay are entitiled to treatment under the EEC's reciprocal health-care rules. Some Italians already go to Paris; Sweden sends heart-surgery patients to London. Europe may soon see the beginnings of what has happened in America: cross-continent specialisation. A hospital that did only hip replacements, for instance, would increase its efficiency and reduce its mortality rate—and attract patients from all over Europe. European countries may find that they are forced by patient pressure to do what they have conspicuously failed to do in the past 30 years: align their systems of health care more closely. ■

Smith Center Offers Screening

The SMITH Center of Springfield Health Department offers hypertension and cholesterol screenings as part of the Wellness Program. The goal of this program is to identify individuals who may be at risk for heart disease and stroke, and refer them to their physicians for further evaluation and treatment as needed.

The Wellness Program uses Massachusetts Department of Public Health referral standards which are based on the criteria set by the National Institutes of Health. Initial blood pressure screening is based on the average of two to three readings. Elevated pressures of ≥ 200/115 are immediately referred to the physician; readings of 140-199/105-114 are referred to the physician within two weeks; and individuals with readings of 140-199/90-104 are requested to come for a rescreen within one month. If elevated on the rescreen, the person is referred to his/her physician.

Cholesterol screening consists of a capillary test performed by a Reflotron chemical analyzer. Those individuals with readings in the borderline high range of 200-240 mg./di are encouraged to discuss this elevation with their physician, to adopt appropriate lifestyle changes, and to be retested in one year. Those whose levels are above 240 mg./di are referred to their physician for more complete assessment, including blood lipid testing, and treatment as needed.

During screenings, the Wellness Program staff also provides health education which addresses lifestyle factors affecting cardiac disease, such as exercise, diet, stress, smoking cessation, and the importance of routine preventative care. Nutritional counseling is available at the SMITH Center. Referrals may be made to smoking cessation programs and counseling agencies as necessary. Individuals with health concerns are requested to consult their physician before beginning an exercise program.

All SMITH Center programs are offered by appointment free of charge; donations are accepted. Further information about the Center's services can be obtained by calling 787-6739, 8:30 a.m.-4:30 p.m. Monday through Friday. ■

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AIDS III

In the face of the mounting flood of attention to the initially recondite subject of AIDS, we wish to continue to direct the attention of our Membership to some of the facts of the fascinating disease. First, there was the original inertia surrounding it. Now there is near panic or at least paranoia in response to its possible presence. Eventually, as physicians, we must adopt our old scientific attitudes towards it, as another fatal communicable disease, until we come up finally with a cure. Prevention will always be better. At present, that essentially involves education followed by behavioral change, both of which remain easier said than done. A vaccine lies far beyond, according to authoritative science.

Meanwhile, the following information was published by the Massachusetts Department of Public Health and Boston D.P.H. and Hospitals, in the January 1988 Number of their *Aids Newsletter.*

Francis J. Riley, M.D., Chairman
Public Health Committee

The Department of Public Health for the Commonwealth of Massachusetts and the Boston Department of Health and Hospitals publish monthly the *AIDS NEWSLETTER* a summary of up-to-date statistics and program information. In the January 1988 edition (Volume 4, Number 1) the authors discuss the following changes noting:

> "Through 1986, the geographic distribution of AIDS cases over time had remained uniform. In 1986, 43% of the AIDS cases were among Boston residents, 45% were among non-Boston residents, and 11% of cases were seen in out-of-state residents who were diagnosed in Massachusetts. Thus far in 1987, the proportion of cases among Boston residents has remained constant at 42%, while the proportion of non-Boston resident cases increased to 53% as out-of-state resident cases fell to 5%."

The four western-most counties in the state, Berkshire, Franklin, Hampshire, and Hampden counties, comprise HSA I or the Western Region, and are used as a group for the reporting of regional AIDS cases. The cumulative totals for these counties as of 12/31/87 are 11 in Berkshire County, 4 in Franklin, 7 in Hampshire, and 40 in Hampden County for a regional total of 62 reported cases of Centers for Disease Control-defined AIDS.

These 62 cases breakdown by risk behavior/activity as follows:

Homosexual/Bisexual Male	52%
Intravenous Drug User	32%
(Heterosexual and Homosexual)	
Heterosexual	8%
(Partners of persons at risk)	
Other	8%
(Hemophiliac, Pediatric, Transfusion, etc.)	

Again, the 82 cases can be broken down by race and by sex. In the current reports race is listed as white and non-white only. Until the numbers of reports are large enough in each racial group to sufficiently avoid the indentification of individuals, these will not be broken down further. The adult cases are as follows:

GROUP	W. MASS #	W. MASS %	TOTAL MASS #	TOTAL MASS %
WHITE	41	(67)	887	(72)
NON-WHITE	21	(33)	348	(28)

The distribution of adult cases by sex, again comparing Western Massachusetts to the totals for the state appears as:

GROUP	W. MASS #	W. MASS %	TOTAL MASS #	TOTAL MASS %
MALE	50	(82)	1118	(91)
FEMALE	11	(18)	117	(9)
TOTALS	61	(100)	1235	(100)

Western Massachusetts has seen an increase in the number of cases but as the total state cases have increased this has led to variations in the percentage of state cases reported from the HSA I area:

continued

LOCATION	THROUGH 82 # %	83 # %	84 # %	85 # %	86 # %	87* # %	TOTAL # %
W.MASS	0 (0)	5 (11)	8 (8)	9 (5)	15 (5)	25 (6)	62 (100)
MASS	23 (100)	47 —	105 —	198 —	299 —	499 —	1138 (100)

Looking specifically at the 40 cases of AIDS reported in Hampden County, 28 of the total are/were residents of the Springfield area at the time of diagnosis. This yields a cumulative incidence rate in the city of 18 cases per 100,000 residents. The cumulative incidence rate for the county is 9 cases per 100,000 county residents as of 12/31/88. Baystate Medical Center has been responsible for the diagnosis of 33 cases to date.

It can be assumed at this point in time between 48% and 52% of persons diagnosed with AIDS are currently living. Total estimates of HIV infected persons can be obtained by multiplying the number of cases of AIDS by fifty. Thus, even though the cases of CDC-defined AIDS are relatively small the impact of HIV infection on the community is much greater. ■

Springfield Academy of Medicine
Continuing Medical Education Program

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September 19, 1988	Risk Management	Frank Reardon, J.D. Crico Malpractice Specialist
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December 12, 1988	AIDS	Brian W. Cooper, M.D.

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Electronic Information for Physicians:
A New Dimension In Solving Traditional Problems Part II

Last time, the capabilities of AMA/NET to assist with diagnostic and therapetic problems were discussed.

III. Current Awareness of Specific Medical Topics

Physicians often need to obtain the latest information in a particular medical subject area. This may be a particular disease state, subspecialty, or a topic of current interest. Traditional sources for such information are the many available medical news publications, scientific meetings, and current medical literature. However, it is often very difficult to sort through the plethora of available information to find the specific items of interest.

This is another area where electronic information. can be helpful. AMA/NET provides a number of services which directly address the need for current medical information. One of the most useful of these is the Associated Press Medical News Service, which provides up to the minute reports of medical news as they are transmitted on the Associated Press newswire. These stories are updated continuously, and are available on both a chronologic basis and by subject area. Medical news stories are thus available almost immediately on AMA/NET.

Another useful source of current information is the literature update by specialty. This provides, via a search of EMPIRES, the most recent literature in a given specialty area. The social and economic aspects of medicine (SEAM) database, which is maintained by the AMA, is another useful source of information. This database references selected articles in both medical and non-medical literature which pertain to social, ethical, and legal issues related to the practice of medicine. Topics of current controversy are often represented in this database.

An additional source of current information in AMA/NET is the public health information services. The Centers for Disease Control, the Surgeon General's office and the FDA all provide current information on AMA/NET. For example, the full text of the weekly Morbidity and Mortality report from the Centers for Disease Control is available.

These sources of information, combined with the literature searching capabilities, make it easy to obtain the latest information on any particular topic of medical interest.

IV. Reference Information

Reference information needed by physicians is traditionally available through a nearby medical library. An example of this type of information on AMA/NET is the CPT procedure codes. The CPT codes are used for reporting most medical procedures to third party payers. This can be useful when such a code is needed and the printed reference is not available.

V. Continuing Medical Education

Continuing medical education has become increasingly important as the rapid pace of medical discovery leads to proliferation of new knowledge and changes in previous concepts. The traditional methods for obtaining continuing education involve attending meetings, either locally or by traveling to a remote location, or reading material followed by subsequent self-administered examinations. More recently, CME has been available in videotape form.

Electronic information has a role to play in CME, also. In particular, computers are well suited for patient simulation type of exercises where the effects of many different patient management scenarios can be explored safely and easily. AMA/NET provides access to a number of such simulations which have been developed at the Massachusetts General Hospital. Examples of these include abdominal pain, diabetic ketoacidosis, and hypertensive emergencies. With these programs, access to electronic information can provide new opportunities in continuing medical education.

continued

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VI. Communications With Colleagues

Traditionally, physicians' communication with their colleagues has consisted of scheduled meetings, either local or remote, chance meetings in the hallway ("curbside consults"), telephone communication (which is very inefficient), and communication by letter, which is frequently used to report the results of patient referrals.

AMA/NET provides access to a new form of electronic communication: electronic mail. With electronic mail, messages are sent immediately, but stored so that each person sends and receives information at their convenience. This greatly simplifies written communication with colleagues since sender and receiver do not need to be simultaneously available. Thus, electronic mail can provide the speed of the telephone without the associated inconvenience and delay, and represents a cure for chronic telephone tag.

Electronic communication can also take the form of an electronic bulletin board, allowing announcements to be made which are immediately accessible to system users.

VII. Non-Medical Information

Physicians also need information that is not medically related. Obviously there are a multitude of traditional sources for all types of information via newspapers, magazines, other periodicals, and television. Electronic information provides a supplement to these sources. In particular, AMA/NET provides on-line access to the Official Airline Guide, which is very useful in planning travel, as well as various types of financial information. The latter includes business press releases, financial and commodity news, tax notes, and stock and commodity quotations. It is also possible to obtain information about investments managed by AMA Advisors.

VIII. Conclusions

Electronic access to information provides an important adjunct to traditional methods. In some cases electronic information provides capabilities which are not otherwise available. In the future, new forms of electronic information will be available. One such form is the "interactive reference," which provides reference information tailored to an individual patient's situation. With such a reference, the process of extracting information relative to a specific patient from a number of sources is performed automatically providing both convenience and time savings.

This report has described some of the information sources and capabilities available on AMA/NET. It is clear that physician access to electronic information greatly expands, but does not replace, traditional information access methods. ■

William A. Yasnoff, M.D., Ph.D.
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Fourth Annual Medical Ethics Forum

Dr. James Fitzpatrick, Chairman of our Medico-Religious Committee, asks us to announce to our members the Fourth Annual Medical Ethics Forum.

The program will be held on Wednesday, September 28, 1988, beginning at 7:00 p.m. in the Cafeteria of Mercy Hospital, 271 Carew Street, Springfield.

The topic of this year's Forum will be "The Jewish Perspective In Medical Ethics". Our speaker will be Fred Rosner, M.D., Professor of Medicine at the State University of New York College of Medicine at Stony Brook and Director of the Department of Medicine of the Queens Hospital Center, New York. Dr. Rosner is a nationally known authority on medical ethics. He has lectured widely throughout the world on Jewish medical ethics and is in great demand as a speaker on this and related topics. Dr. Rosner has also published extensively on medical ethics and Jewish medical history, and is the author of four widely acclaimed books on Jewish medical ethics, the last of which, *Modern Medicine and Jewish Ethics,* is an up-to-date examination of the Jewish view on many important bioethical issues in medical practice.

Our annual Forum objectives are to bring together various health professionals to assess their needs for greater clarification of medical ethical issues; to be able to identify methods of dealing with ethical issues; and to present and have discussion regarding current medical ethical dilemmas.

Physicians will be awarded 3 Category I CEU's from the Springfield Academy of Medicine for attending this Forum. The Forum has also been approved for 3.6 Contact Hours for Registered Nurses and Licensed Practical Nurses. Credits for Social Workers have been applied for.

The fee for this Forum is $12.00. To register, please call the Society's office at 736-0661.

We ask our members to support Dr. Fitzpatrick and his hard-working Committee members. Attend and get involved! ■

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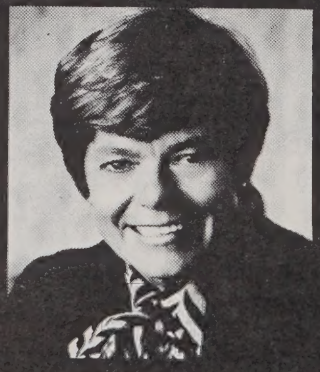

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The Cynic's Bulletin

Snavely S. Reptile, famous Massachusetts malpractice attorney having failed to win the Democratic nomination for president, has signed on as health policy advisor for the Dukakis campaign.

Reptile was accused of conflict of interest, given his long history of aggressive antagonism towards the medical profession, and the fact that he was currently conducting a class action suit against members of the specialty of Internal Medicine in the state of Massachusetts. (The genesis of the case was that Reptile's wife, Myrtle, had developed a severe sunburn while sunning herself on a rock. She applied a compress made of leaves gathered from a nearby bush, which unfortunately turned out to be poison ivy. When the problem became mush worse, she immersed herself in a pool of water to cool down the burning and itching. Unfortunately, this turned out to be full of Portuguese Men of War, and their reaction to her presence resulted in further complication of her problem. As she attempted to find help, she inadvertantly knocked over a hornet's nest, and suffered massive insect stings. Myrtle barely made it back to where she could get help, and was rushed to a local hospital in extremis.

At that point, Dwight M. Winkle, M.D., a well-respected local internist, was asked to assume her care. Putting aside his prejudices against Reptile, (Winkle lived in a dumpster and commuted to work on an abandoned bicycle, having lost a malpractice case to Reptile, and consequently, everything he owned) he worked day and night over a period of eleven weeks, until Myrtle was completely healed, at which point he collapsed.

Reptile learned subsequently that Winkle had no credentials in Dermatology, and in fact was a specialist in Internal Medicine. He also discovered that Internal Medicine Specialists throughout the Commonwealth frequently treated patients with skin diseases which were obviously external. Since suing Winkle would not have been worth it (Winkle had nothing and was given a very short time to live) Reptile mounted a class action suit against the Specialty of Internal Medicine on behalf of patients with skin disorders who have been treated by them. Legal observers in Massachusetts predict that Reptile will win, and the resulting award should catapault Reptile into the company of individuals whose net worth is greater than all but three or four countries.)

Reptile pointed out, however, that he had made a number of discovery, continuance , and *sine qua non* motions designed to tie the case up until after January when Dukakis was sworn in. He also made it clear that he was not intrinsically prejudiced against physicians, as he had refused to sue the Massachusetts Medical Society, which had been one of the organizations which complained about Reptile's apparent lack of objectivity.

In an interview, Reptile was asked to list reasons why he supported the candidacy of Michael S. Dukakis.

"First," said Reptile, "Dukakis is Greek. As you know, our entire political heritage stems from Greek ideas. Dukakis is obviously in a better position to understand Greek things than any other political candidate.

Second, we have never had a Jewish first lady. It is high time this great country remedy this slight against an entire ethnic group. If there were no other reasons than this, I would feel compelled to vote for Dukakis.

Third, Dukakis, a liberal Boston Democrat, is running with Bentsen, a conservative Texas Democrat. The last time this happened, the entire country was euphoric. There seems to be a natural resonance between the people of this country and that particular combination of leadership.

Fourth, Dukakis is much better prepared to deal with Michael Gorbachev than is George Bush. Dukakis and Gorbachev have the same first names as well as strange, foreign-sounding last names; they are both extremely short, and can see eye-to-eye on many subjects. Gorbachev has a disfiguring birthmark on his forehead; Dukakis has peculiar eyebrows. They will each have something to stare at when thay have summit meetings. They are both from one-party states.

Fifth, Dukakis snowblows his own driveway, mows his own lawn, and is real handy around the house. Think of how much money that will save in terms of White House operating expenses.

Sixth, Olympia Dukakis won an academy award this year. If Dukakis wins the presidency, think of the symmetry! Two cousins both winning something big the same year.

Seventh, and this is of particular interest to physicians, whom I expect will contribute heavily to the Dukakis campaign, the Governor's father was a physician. In fact, when Michael was a young lawyer, he was asked to sue his father by a disgruntled patient who claimed that Dr. Dukakis has prescribed pills whose color clashed with the patient's evening gown, thus causing great social embarrassment. Governor Dukakis respected his father so much that he persuaded the client to settle out of court, rather than destroy his father's livelihood and reputation through a prolonged and exhausting court case, as would have been done otherwise."

In a probably unrelated development, a peculiar earth tremor continues to be of concern to the city officials of Brookline, Massachusetts. Ever since Governor Dukakis was nominated for the presidency, a continuous earthquake has shaken windows and knocked small objects off of shelves. The epicenter of the earthquake has been traced to the Brookline Greek Orthodox Cemetery,

continued

The Cynic's Bulletin

continued

ironically at the gravesite of Panos Dukakis, M.D. "Its as though something down there is spinning around at an incredible rate of speed," said W. W. Meeks, the town engineer.

George Bush, the Republican candidate, is beginning to respond to the impact of the Dukakis candidacy on the electorate. His statements and actions during the last few days have indicated he is worried.

Item: Bush announced that he was planning to run as his own vice president, since a) he had more experience in this job than any other living American; b) he could then run as a liberal New England Republican and a conservative Texas Republican, thereby counteracting the Dukakis campaign ploy.

Item: Bush announced that his wife, Barbara, had converted to Judaism.

Item: Bush revealed that geneologists had determined that he also had an ethnic background, in that one of his great-great-great-great grandfathers was rumored to be part Welsh.

Item: Bush, in a major foreign policy address, stated that he would be in a better position than Dukakis to meet with Michael Gorbaschev because they are probably related. Some scholars feel that the name "Bush" derives from the Slavic "Gorbaschev". In prehistoric times, a tribe of slavs migrated over the polar cap to Great Britain where they settled down with the Druids and Picts, and through centuries of crossbreeding, gradually lost their identity. The only remnant of this branch of the Gorbaschev tribe is the surname "Bush" which came from the Anglo Saxon tendency to drop prefaces and suffixes.

Item: Bush has announced that he, too, is handy around the house. He has not had a butler in more than ten years, preferring to supervise the servants himself.

Item: Although Mr. Bush does not have any physicians in his family, he is quick to point out that he has had routine physical examinations from physicians.

Item: Mr. Bush points out that he also has a cousin who recently won an academy award, (Cheryl Bush, more popularly know as "Cher"). Bush acknowledges that members of his family were too refined to flaunt such things in public and that Cher would probably publically deny any relationship at all. As predicted, she did.

Candidate Bush made it clear that he would meet Mr. Dukakis issue for issue, head to head, nose to nose, and toe to toe.

R. Cynic, M.D.

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MEDICAL:	Hahnemann, Pennsylvania 9/73-6/77
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RESIDENCY:	Bridgeport Hospital, Connecticut 7/78-6/80
FELLOWSHIP:	Geisinger Medical Center, Pennsylvania 7/83-6/86
SPECIALTY:	Cardiology/Internal Medicine

David B. McQuade, M.D.
Noble Hospital
115 West Silver Street
Westfield, MA 01085

BORN:	March 7, 1952
PREMED:	University of Oklahoma 1969-73
MEDICAL:	University of Oklahoma 1976-80
INTERNSHIP:	Strong Memorial Hospital, NY 1980-81
RESIDENCY:	Strong Memorial Hospital, NY 1981-84
SPECIALITY:	Diagnostic Radiology

IN MEMORIAM

ROBERT D. HARRINGTON, M.D.

Dr. Robert D. Harrington died on July 22 at Baystate Medical Center.

Bob Harrington was a graduate of Tufts College Medical School. He completed an internship at the Rhode Island Hospital and a residency in psychiatry at the University of Colorado Medical Center. During his years in the Springfield area he was affiliated with the Western New England Psychoanalytic Institute, with the Wesson Women's Hospital, with Smith College, with the Baystate Medical Center and, most notably, with the Hampden District Mental Health Clinic where he served as Executive and Medical Director for nearly 30 years.

Bob's career as a psychiatrist in Springfield spanned an important time for the community mental health movement. As Director of the Hampden District Mental Health Clinic and an early member of the Baystate Medical Center, Bob was intimately involved with the events of community-based services for patients. During his years as a practicing psychiatrist in Springfield, Bob gained the respect of his colleagues, as well as that of his patients. He brought to the complex task of caring for psychiatric patients, a wisdom, calmness, and tolerance which served as a model for his colleagues. Bob had dedication to his profession but he also had a perspective on other important aspects of his life, his family and his friends.

Dr. Robert Harrington will be fondly remembered not only by his patients, his friends, and his staff, but also by his colleagues in the psychiatric profession who hold him in the highest regard. He leaves his wife Margaret and five children, two of whom are physicians. His passing has also left an irreplaceable void in the Springfield psychiatric community.■

Benjamin M. Ianzito, M.D.
Department of Psychiatry
Baystate Medical Center

New Vaccine Reporting System Announced By State Health

I recently saw a different number of ubiquitous automobile signs—"Live Free Or Live In Massachusetts". While apparently humerous, that one, like the others tells only a part of the story.

Another part is the Massachusetts Department of Public Health, which has continued to do its best over the years, in the presence of all the changes in medicine, as well as in the public-at-large (larger and larger) and in our own profession. The accompanying announcement of changes in the Mass. Public Health Department's Vaccine Program is a case in point. This State has led the way in its supply of vaccines free to its taxpayers. It is still trying to do so, within the bounds of reason, again in the presence of the changing patterns of disease and the economic facts of life (with or without President Michael Dukakis).

Accordingly, the Mass. Department of Public Health enlists the cooperation of the vaccine users among us.

Francis J. Riley, M.D., Chairman
Public Health Committee

In Massachusetts, vaccines have been distributed by the State without charge to private and public providers for nearly 40 years. However, significant cost increases threaten the ability to continue this policy of universal vaccine distribution. According to the Division of Communicable Disease Control, the State price for MMR, for example, has increased from $2.71/dose in 1980 to $16.18 in 1988. The private purchase price is now $27.23.

In order to improve vaccine monitoring capabilities and minimize vaccine wastage, the State has developed a new vaccine accountability system which utilizes an optically-read scanner to analyze vaccine distribution and usage patterns. This system will analyze current usage patterns, identify areas where renewed emphasis on immunizations may be needed, and also provide practitioners with periodic reports concerning age-appropriate immunization levels for their practice. Informational packets introducing the new forms are being mailed to the nearly 4,000 vaccine users statewide. Vaccine distribution sites will begin instituting this initiative as providers pick up additional vaccine supplies.

All health care providers using State vaccines are urged to lend their support to maintaining this important public health program. ■

NOTE: If you have any questions call the Western Massachusetts Immunization Program which is in Amherst at 549-1045.

Free Books

The Springfield Academy of Medicine is weeding its library and plans to donate its outdated monographs to the annual booksale sponsored by the Friends of Springfield City Library. All HDMS members are cordially invited to visit the Academy and puruse the discard collection to see if any of the books would be of value to them. The weeding will provide space to shelve the burgeoning journal collection and some more current reference materials. ■

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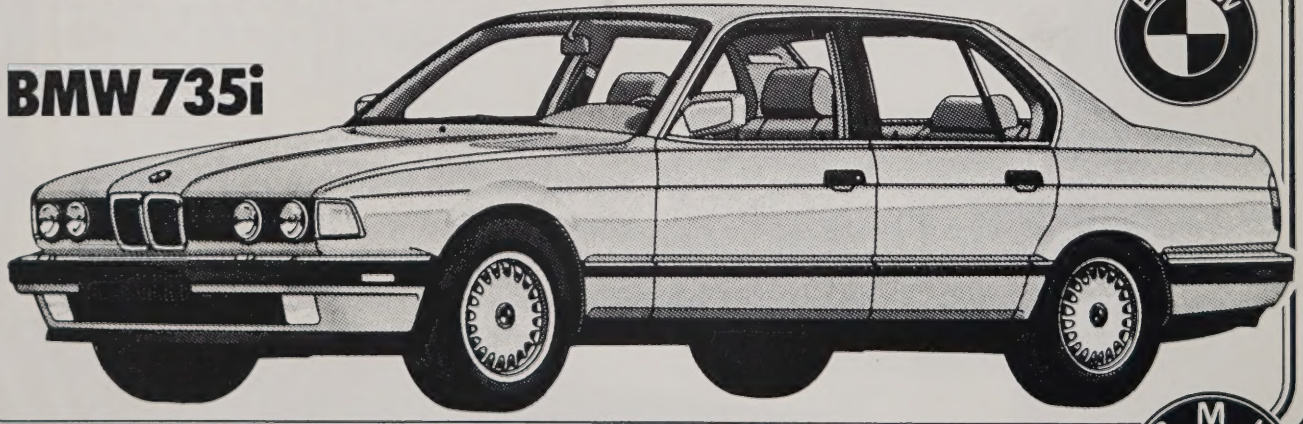

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